EMS-501 (10/11)

Michigan Department of Community Health
EMS AND TRAUMA SYSTEMS SECTION
P.O. Box 30437
Lansing, Michigan 48909
(517) 241-0179
Website: www.michigan.gov/ems

Authority: P.A. 368 of 1978, as amended
This form is for information only.

RE-LICENSURE INSTRUCTIONS

INSTRUCTIONS FOR MFR, EMT, EMT-SPECIALIST AND PARAMEDIC

To qualify for re-licensure your previous Michigan EMS license must have expired within the last three years. All other applicants must use the initial Application for Licensure form.

1. Complete the re-licensure application form EMS-501 marking the box for the appropriate level you are applying to re-license. Submit it with the appropriate fee to the EMS & Trauma Systems Section with the check or money order made out to the State of Michigan. **Application fees are non-refundable.**

2. If you have a yes answer to question number 1 on the application, you must complete the attached criminal conviction history form DCH-HLD-002 (8/11).

3. If you have a yes answer to question 2 on the application, you must submit a detailed explanation with your application.

4. With your application submit copies of certificates or other acceptable documentation of continuing education credits and a copy of your current CPR card (front and back). **Refer to EMS Personnel Continuing Education Form BHPPA/EMS-127 for category and lecture/practical requirements which can be obtained on the website.** *All continuing education credits must* ***have been completed within three years of the date of the re-licensure application.***

5. If you have been licensed in another state, since the expiration of your Michigan license, you are required to forward a *Verification of Out-of-State Licensure Form (EMS-251)* to the licensing agency in each state for their completion and submission directly to this office. National Registry is not a state; therefore, do not send this form to the National Registry.

6. Failure to complete the application in its entirety and correctly may result in a delay of the processing of your application. **This is a two-page application.** Be sure to complete both pages/sides, sign and date your application before submitting with the appropriate fee.

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APPLICATION FOR RELICENSURE - LICENSE EXPIRED WITHIN LAST 3 YEARS

Authority: Public Act 368 of 1978, as amended.
If this form is not complete a license will not be issued.

Type or Print Only

I AM APPLYING FOR: (Check ONE only)

- ☐ **Medical First Responder - Fee: $50.00 71-3204-06**
- ☐ **Emergency Medical Technician (Basic) – Fee: $75.00 71-3203-06**
- ☐ **EMT-Specialist (NR-Intermediate 85) – Fee $75.00 71-3202-06**
- ☐ **Paramedic – Fee: $75.00 71-3201-06**

State Office Use Only
License Number
Date of Licensure

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. DO NOT SEND CASH. **Fees are deposited upon receipt and are NON-REFUNDABLE**.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth

Street Address

City	State	ZIP Code

All Previous Names and/or Birth Name Used (If Applicable)	Daytime Phone Number

Check the appropriate answer to each of the following questions.

1. Have you been convicted of a misdemeanor or felony, other than minor traffic violations? ☐ Yes ☐ No
   NOTE: Attach criminal conviction history form DCH-HLD-002 (8/11) for a Yes answer

2. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined, been denied a license or currently have disciplinary action pending against you? ☐ Yes ☐ No
   NOTE: Attach a detailed explanation for a Yes answer

3. Do you hold, or have you ever held an emergency medical services **license** in any other state? List each state, the license number, and the date issued. **You must have each state's licensing agency verify licensure directly to this office.** (Attach additional sheets, if necessary) ☐ Yes ☐ No

State	License/Registration Number	Date of Issue

Name	Social Security Number

CERTIFICATION

I certify that I am the person named on this application and that all statements are true. Once licensed, I will comply with all applicable state laws and rules.

I understand that it is the policy of this agency to secure criminal conviction history as part of the pre-licensure screening process, and I authorize the agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record keeping organization.

I further consent to the release of information to this agency regarding any discipline investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state of the United States, military branch of the federal government or any sovereign nation.

The statements in this application are true and correct. I have not withheld information which might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation may be punishable by law.

Signature	Date

EMS-251 (7/11)

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VERIFICATION OF OUT-OF-STATE LICENSURE

Authority: Public Act 368 of 1978, as amended.

PART I – To be completed by the applicant and forwarded to the appropriate State Licensing Agency for completion.

Please indicate the level of licensure for which you are requesting verification:

☐ Medical First Responder ☐ Emergency Medical Technician ☐ EMT-Specialist/Intermediate 85 ☐ Paramedic

First Name	Middle Name	Last Name

All Previous Names and/or Birth Names Used (if applicable)	Date of Birth	Social Security Number

State Agency	License Number	Date of Issue

The applicant named above has applied for licensure in Michigan and has indicated licensure in your state. Please complete Part II of this form and return it to the address shown above. (**Must be received with original signature, faxed copies are not accepted**)

PART II – To be completed by the State Licensing Agency

License Type	License Status	Expiration Date
	☐ Current ☐ Lapsed ☐ Inactive	

Has the applicant incurred and disciplinary proceedings in your State?
☐ No ☐ Yes (If yes, please attach **certified** copies of any actions.)

Are disciplinary proceedings pending?
☐ No ☐ Yes

Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended, or revoked?
☐ ***No*** ☐ ***Yes (If yes, please attach*** *certified* ***copies of any actions.)***

If applying for **MFR,** Did the applicant's training include the following:
☐ Spinal Immobilization, ☐ Epi Pen

If applying for **EMT**, Did the applicant's training include the following?
☐ Supraglottic airway (e.g., combitube, king), ☐ Epi Pen, ☐ Albuterol

If applying for **EMT Specialist (Intermediate 85)**, Did the applicant's training include the following (check the appropriate box(es)?
☐ IV Therapy (fluid replacement only) ☐ Endotracheal intubation ☐ Supraglottic airway

If applying for **Paramedic**, Did the applicant's training include (check the appropriate box(es)?
☐ IV Therapy ☐ Medication administration ☐ Endotracheal intubation ☐ Manual defibrillation

If this person is currently licensed as an EMT Specialist (Intermediate 85) or Paramedic, do they currently hold or have they held in the past, certification/licensure at the EMT level?
☐ No ☐ Yes

CERTIFICATION

I hereby certify that, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature Date

_____ _____
Type or Print Name Title

_____ (S E A L)
Name of Licensing Agency

_____
Phone Number

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs know to this agency

DCH/HLD-002 (8/11)

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CRIMINAL CONVICTION HISTORY FORM

Authority: Public Act 368 of 1978, as amended

The Department has received information which indicates you have been convicted of a misdemeanor or felony. Additional information is necessary to process your application. Please complete this form and mail it to the address above or fax it to: (517) 241-9458. Processing of your application is being delayed until this information is received.

First Name	Middle Name	Last Name
U.S. Social Security Number	Drivers License Number	Type of license you are applying for

Conviction #1 Information	Conviction #2 Information
Briefly state the nature of the conviction	Briefly state the nature of the conviction
Date of Violation	Date of Violation
Date of Conviction	Date of Conviction
County, State, & Court of Jurisdiction	County, State, & Court of Jurisdiction
Sentence	Sentence
Please check, if applicable and give date: □ Expunged on: ____/____/____ □ Annulled on: ____/____/____	Please check, if applicable and give date: □ Expunged on: ____/____/____ □ Annulled on: ____/____/____

NOTE: The back of this form may be used if you have more than two convictions

CERTIFICATION

I hereby certify that the above facts and any attached statements are true, accurate, and complete about any and all convictions, and further make application for licensure in Michigan.

Signature of Applicant/Licensee	Date

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.